Appendix 10
Reading the Medicaid Remittance and Status (R/S) Report

The Medicaid R/S Report is sent to providers each week that at least one claim has been finalized. The R/S Report is the best tool for understanding Medicaid claim payments and for identifying denials or mispayments for prompt action.

A list of pending claims also appears once a month on the last R/S Report of the month. This includes claims that have pended 30 working days and longer and is designed to help avoid unnecessary "tracers" or "second billings."

The following item-by-item description explains the basic information that always appears on the R/S Report.

(*Note:* Financial items and identifying information may also appear to acknowledge special transactions such as voluntary refunds by the provider or any Medicaid check that is outstanding beyond 90 days.)

Please refer to Appendix 8 of this section for a completed sample R/S Report including a banner page and Appendix 9 for a sample R/S Report with a prior authorization request.

Banner Page

Wisconsin Medicaid advises providers to read the banner page for important information that may apply to all providers or to specific provider groups. The page may include information on Medicaid-initiated adjustments, claim submission deadlines, and upcoming seminars. Providers should also maintain the banner page with the entire R/S Report.

Header Information

1H. **Provider Name and Address** - Name and address of the billing provider payee. (This is not necessarily the name of the billing provider.)

2H. **R/S Number** - R/S Report number.

3H. **Provider Number** - Billing provider's eight-digit Medicaid provider number.

4H. **Remittance and Status (R/S) Report Date** - Date the R/S Report and check were printed.

5H. **Page** - Page number (for this R/S Report). Paid/denied claim information generally starts on page 2.

6H. **Report Sequence Number** - R/S Report Series. This number indicates the number of R/S Reports the provider has received that year.

Paid/Denied Claim Adjustment and Prior Authorization Information

Double check for correct processing — these are key items that could affect payment or denial.

1A. **Patient Name** - Patient's last name and first name (or first initial). The recipient's most current name on file will always appear on the R/S Report. If the recipient has changed names, the name on the R/S Report will not necessarily be the name on the claim submitted by the provider.

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2A. **Patient ID Number** - Recipient's ten-digit Medicaid identification number.

3A. **Medical Record Number** - For claim or adjustment, patient medical record number as recorded on the Medicaid claim. For prior authorization (PA) or spell of illness (SOI) request, prior authorization number as recorded on the Medicaid claim.

4A. **Accounting Number** - Patient account number as recorded on the Medicaid claim.

5A. **Claim Number** - Unique 15-digit number assigned by Medicaid to that claim, adjustment, PA, or SOI request. Refer to Appendix 7 for an explanation of the claim number.

6A. **Service Dates** - Dates of service (or date range) corresponding to when the service(s) or supply item(s) were provided.

7A. **Unit Dose (when applicable)** - The unit dose indicator as recorded on the Medicaid drug claims.

8A. **No Substitute (when applicable)** - The no substitute indicator as recorded on the Medicaid drug claims.

9A. **Performing Provider/Rx Number** (when applicable) - The performing provider number of the provider who performed the service or the prescription number.

10A. **Days/Quantity** - Number of visits, accommodation days, or supply quantity billed.

11A. **Procedure/Accommodation/Drug Code** - Alphanumeric code for the service(s) or supply item(s) provided. Modifiers may also be indicated following the code. The alphanumeric character preceding this code is the type of service (TOS) code.

12A. **Procedure/Accommodation/Drug Description** - Narrative description of the service(s) or supply item(s) provided.

13A. **Total Billed** - For claims or adjustments, total billed charges for the service(s) or supply item(s) shown on that line. For PA or SOI, total number of services requested.

14A. **Total Allowed** – Medicaid payment allowance (determined according to appropriate reimbursement criteria).

15A. **Other Deducted Charges** (when applicable) - Charges deducted from total allowed for reasons such as other insurance payment, patient liability (nursing home claims), or recipient spenddown.

16A. **Copay** (when applicable) - Copayment amount deducted from total allowed amount.

17A. **Paid Amount** - Actual amount of the Medicaid payment.

18A. **EOB Codes** - Numeric code that corresponds to a printed message about the disposition of the claim, adjustment or PA request *detail*. (A list of the EOB codes used, with their narrative description, appears on the last page of the R/S Report.)

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Reminder:

1R. Wisconsin Medicaid checks not cashed beyond 90 days.

Payment Summary Information

1P. **Claims Payment Summary** - Amount of actual Medicaid payment made in this week's check.

2P. **Claims Paid** -
   a. Current Processed - Total number of claims processed on this R/S Report.
   b. Year-to-Date Total - Total number of claims processed since the beginning of the calendar year.

3P. **Claims Amount** -
   a. Current Processed - Total dollar amount for the claims paid on this R/S Report.
   b. Year-to-Date Total - Total actual claims payments since the beginning of the calendar year.

4P. **Withheld Amount** -
   a. Current Processed - Dollar amount of any withheld payments (e.g., negative adjustments) on this R/S Report.
   b. Year-to-Date Total - Dollar amount of payments withheld (e.g., negative adjustments) since the beginning of the calendar year.

5P. **Credit Amount** -
   a. Current Processed - Dollar amount of any voluntary refunds dispositioned in the previous week.
   b. Year-to-Date Total - Dollar amount of voluntary refunds dispositioned since the beginning of the calendar year.

6P. **Net 1099 Amount** -
   a. Current Processed - Net earnings for the claims shown on this R/S Report.
   b. Year-to-Date Total - Net earnings calculated from the beginning of the calendar year.

Medicaid sends an R/S Report showing each claim, adjustment, or PA that finalized processing for that period. Providers are encouraged to reconcile each R/S Report as soon as it is received (e.g., post any payments made and the date of the R/S Report to the patient's account, submit adjustment requests, if required, or correct and resubmit denied claims).